



OVERVIEW OF ADVANCE CARE PLANNING & TOOLS TO DOCUMENT HEALTH DECISIONS

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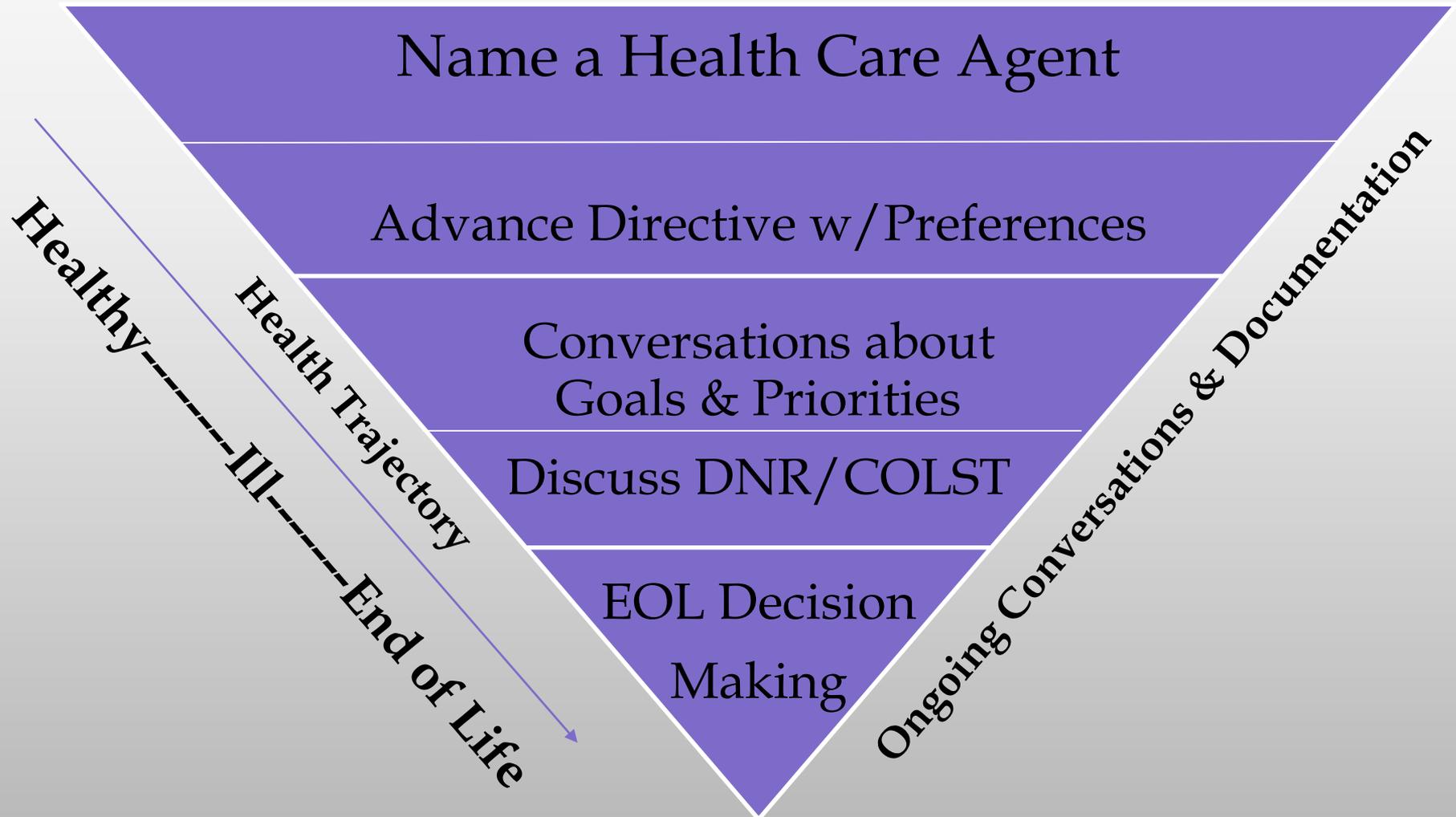
Advance Care Planning Terminology

- **Advance Care Planning** = Planning in Advance of Serious Illness
 - Appointing a Health Care Agent
 - Completion of Advance Directives with Discussion about Preferences
- **Serious Illness Conversation** = Planning in the context of progression of serious illness
 - Diagnosis of Serious or Chronic Illness(es)
 - Progression of Serious or Chronic Illness(es)
- **Goals of Care Conversation** = Decision making in the context of clinical progression, decline, crisis, poor prognosis

Tools for Documentation

- **Advance Directives (AD):** Preference-based documents *completed by decisional patients* to guide **future** medical decisions.
 - Allows for appointment of health care agent & explanation of goals, values, preferences and priorities.
 - Typically nuanced documents requiring discussion, context and interpretation.
- **DNR/COLST Orders:** Medical orders to guide **current** treatment decisions.
 - Completed by clinicians (MD, DO, PA, APRN)
 - Require informed consent (patient, agent, guardian, surrogate)
 - Based on the patient's current medical condition **AND** their goals and values.

ACP Continuum



The Vermont AD Registry (VADR)

- Online repository for advance directives
- Part of the National US Living Will Registry
- Free for Vermont residents
- Hospitals are required to check the registry when a patient who lacks capacity is admitted or provided services (18 V.S.A § 9709)
- Additional forms for submitting documents to registry & for making changes once a document has been submitted
 - Registry Agreement (new registrations)
 - Authorization to Change Form

Benefits of ACP Conversations & ADs

Improved Quality & Value of Health Care

- Care better aligned with patients' preferences
- Fewer non-beneficial medical interventions
- Less distress for family and caregivers
- Lower costs

Benefits of Advance Directives

- Less likely to die in the hospital
- More likely to receive goal concordant care
- Better surrogate communication with providers near end-of-life
- Receive less costly care in some regions

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